Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 20, 2017	2017_370649_0012	020958-15, 018653-16, 020092-16, 026927-16, 027091-16, 027258-16, 027260-16, 027270-16, 027751-16, 028016-16, 031115-16, 031549-16, 031906-16, 032014-16, 033190-16, 035450-16, 000178-17, 000340-17, 000482-17, 000658-17, 001499-17, 001500-17, 002116-17, 002957-17, 003648-17, 004989-17, 005193-17, 009241-17, 010609-17, 011143-17, 011160-17	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

St. George Care Community
225 ST. GEORGE STREET TORONTO ON M5R 2M2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JULIEANN HING (649), NATALIE MOLIN (652), NITAL SHETH (500), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 16, 17, 18, 19, 23, 24, 25, 26, 30, 31, June 1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, and 22, 2017.

The following Critical Incidents were inspected:
Allegation of Staff to Resident Abuse – log #009241-17 and 010609-17.
Responsive Behaviours – log #027260-16, 028016-16, 031906-16, 033190-16, 000178 -17, 000340-17, 000482-17, 003648-17, and 000658-17.
Resident to Resident Abuse – log # 027270-16, 035450-16, 002116-17, 005193-17
Unexpected Death – log # 001500-17.
Falls – log # 020092-16, 031549-16, 011143-17 and 011160-17.
Bed Rail – log # 031115-16.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Cares (ADOCs), Director of Resident Program, Environmental Service Manager (ESM), Physiotherapist (PT), Nurse Managers (NM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Behavioural Support Ontario (BSO) Lead, Resident Assessment Instrument (RAI) Co-ordinator, Housekeeping, Receptionists, Scheduling Co-ordinator, Scheduling Clerk, Smoking Attendants, Substitute Decision Makers (SDMs), and Residents.

During the course of the inspection, the Inspector observed staff to residents interactions, conducted interviews, reviewed relevant policies, and residents' health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

14 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Record review of CI reported to the Ministry of Health and Long-Term Care (MOHLTC) indicated on an identified date resident #040 slipped on the floor and fell and was diagnosed with an injury to an identified body part.

Interview with Registered Practical Nurse (RPN) #178 revealed that he/she did not observe the resident using his/her mobility device on the day of the fall. RPN #178 revealed that the resident has identified responsive behaviours. RPN #178 revealed he/she left the resident for a moment heard yelling and found the identified resident on the floor. The RPN further revealed that he/she was unaware that the resident was at risk for falls.

Interview with Registered Nurse (RN) #180 revealed that the staff should not have left the resident unattended.

Interview with Director of Care (DOC) revealed that he/she expected the staff to stay with the resident to ensure the resident's safety. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee shall ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the CI indicated resident #015 sustained an injury to identified body parts. Personal Support Worker (PSW) #161 indicated that the resident sustained an injury during care.

Interview with PSW #161 confirmed an identified number of staff were to provide care when the resident has an identified behaviour. He/she tried to provide care when the resident had an identified behaviour.

Interview with RPN #162, and #163 revealed that PSW #161 reported that the resident had an identified behaviour and sustained an injury. RPN #162 further revealed that he/she provided treatment to the site of injury. RPN #162 and #163 confirmed that the care had not been provided to the resident by the identified number of staff.

Interview with DOC revealed that the resident should have received care from the identified number of staff as specified in the plan of care. [s. 6. (7)]

2. Record review of CI submitted to the MOHLTC indicated a resident to resident altercation between resident #036 and #037 in an identified area of the home witnessed by staff #176.

Record review of resident #033's responsive behaviour written plan of care revealed interventions that included monitoring behaviours at identified intervals on the Dementia Observation System (DOS) form.

Record review of resident #033's clinical record included follow up an identified outreach team on an identified date. The outreach team provided the home with identified recommendations.

Record review of DOS form was not completed on an identified shift at identified times.

Interview with PSW #137 revealed he/she could not remember if he/she monitored resident #033 at identified intervals on identified shifts and he/she did not document on the resident’s DOS form.

Interview with Assistant Director of Care (ADOC) #118 reported the home’s expectation is that after a resident to resident identified interaction and when residents exhibit new responsive behaviours, they should be monitored by staff at identified intervals and complete documentation on the DOS form for an identified number of days on all shifts. ADOC #118 stated that PSW #137 should have monitored resident #033 at identified intervals and documented on the DOS on identified dates, after resident had identified interactions with two other residents. [s. 6. (7)]

3. Record review of CI submitted to the MOHLTC reported resident #001 stood up from identified mobility aid and lost his/her balance sustaining an injury to an identified body area.

A review of resident's #001's written plan of care directed staff to assist the resident back to bed after each meal.

Observations on identified dates and times revealed the resident was sitting in his/her mobility aid in an identified area of the home, stood up and a fall prevention device triggered. A staff who was in the area immediately attended to the resident and took the resident to his/her bed.

Interview with RPN #173 revealed that the resident stood up from his/her mobility aid and sustained an injury on an identified date and time.

Interview with PSW #168 revealed that resident #001 usually goes back to bed after

breakfast and the care plan was not followed on the day of the injury as the resident did not go back to bed.

Interview with PSW #204, Physiotherapist (PT) #174 and RN #106 revealed that if resident #001 is left in a mobility aid in an identified area of the home he/she will try to stand up, walk and fall. PT #174 further revealed that if resident is left in a mobility aid for prolong periods he/she will try to stand. RN #106 revealed that the resident has to be monitored closely.

Interview with ADOC #118 and DOC revealed that the resident should have gone back to his/her bed to prevent falls. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Record review of a CI submitted to the MOHLTC reported resident #018 had an identified interaction with resident #019 in an identified area of the home.

Record review of #018's written plan of care revealed the resident had an identified responsive behaviour related to an identified medical condition.

Interventions included monitoring of the resident, monitor resident's responsive behaviours for an identified number of days, then reassess.

Interviews with PSW#119, RNs #116 and #117 reported that the DOS documentation is started after a resident to identified interaction and had continued for an identified number of days, then reassess.

Record review of resident #018's incident reports confirmed the above mentioned incident and another identified interaction with another resident on an identified date. A staff member discovered the two residents in an identified area of the home and intervened and prevented the situation from escalating.

According to another incident report resident #018 on an identified date was witnessed by staff having an identified responsive behaviour towards #020 in an identified area within the home.

Record review of the identified resident's DOS documentation was not completed on

identified dates and times.

Interviews with PSW #132 and #113 reported that he/she monitored resident #018 on identified dates but did not complete the DOS documentation.

Interview with PSW #139 reported he/she was was not aware that the DOS documentation was to be completed for the identified resident on an identified date however the resident was monitored during the shift.

Interview with RPN #102 reported that he/she did not check to ensure that the DOS documentation was completed by the PSW staff for the resident #018 on identified shift and date.

Interview with PSW #137 reported being familiar with residents #018, and #020, and worked on an identified shift after the identified interaction between the two residents had occurred. He/she stated that he/she checked resident #018 at identified intervals but did not document on the resident's DOS because he/she did not see the DOS sheet.

Interview with ADOC #118 revealed that PSW staff should have completed resident #018's DOS documentation after resident to resident altercations on specified dates, and registered staff should check at the end of each shift that the documentation is complete. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Record review of CI reported to the MOHLTC indicated on an identified date resident #040 slipped on the floor and fell and was diagnosed with an injury to an identified body part.

A review of the home's policy titled Falls Prevention, # VII-G-30.00, revised January 2015, revealed that the registered staff will complete the Falls Risk Assessment in the electronic documentation system at the following times:
-Within 24 hours of admission or readmission
-A significant change in status, i.e. when there is physiological, functional or cognitive change in status

A review of resident's #040 assessments indicated that the Fall Risk Assessment had been initiated on an identified date but was not completed.

Interview with RN #145 and DOC revealed that the Falls Risk Assessment had not been completed for resident #040. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A review of the home's Bed Entrapment Audit for 2015, and 2016, revealed that the home conducted bed entrapment audit for zones one to four for all beds. The home did not consider evaluation of zones five to seven for all beds in the home.

A review of the home's policy titled Bed Entrapment, #VII-E-10.30, issued January 2015, and revised April 2016, indicated the Environmental Service Manager (ESM) or designate will assess bed systems annually for all seven zones of entrapment.

Interview with ESM revealed that the home's 2015 bed entrapment audit was conducted by Cardinal Health Canada, and at that time, the home had four quarter rails on all beds. They were supposed to audit for all zones one through seven. In 2016, ESM conducted the bed entrapment audit and at that time, all beds had only two rails, bottom rails were not there, therefore zones five to seven were not audited because it only applied to bottom rails. He/she was not aware that there is a specific form for the bed entrapment audit, and he/she used the one he/she created.

Interview with the DOC and the Executive Director (ED) confirmed that ESM used the wrong document for the bed entrapment audit, and all zones should be audited to identify and minimize the risk associated with bed entrapment when rails are in use. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Record review of a CI submitted to the MOHLTC indicated there was an identified interaction between resident #018 and resident #019 in an identified area of the home.

Review of resident #018's clinical record included identified medical conditions. The resident's CPS was three indicative of moderate impairment.

Record review of the resident's written plan of care revealed the resident has responsive behaviours related to identified medical condition. Interventions included monitoring the resident, monitor behaviour episodes, document behaviour and potential causes.

Record review of resident #018's incident reports revealed five documented incidents of identified interactions between resident #018 and co-residents.

Record review of CIs submitted to the MOHLTC reported resident to resident interactions had occurred on identified dates.

According to resident #018's progress notes, he/she was roommates with resident #019 until an identified date when resident #018 was transferred into another room due to the identified interactions with resident #019 on identified dates. Subsequently, two more identified interactions occurred in an identified area of the home between resident #018 and #020 on identified dates; resident #018 was then transferred to a different floor on an identified date.

Record review of resident #018's clinical record revealed a referral to the identified outreach team was completed on an identified date and the resident was later assessed.

Interview with RN #117 revealed that he/she completed a referral for assessment of

resident #018's responsive behaviours by the identified outreach team on an identified date and it should have been done sooner as the resident had been exhibiting responsive behaviours and documented incidents. Resident #018 has responsive behaviours related to an identified trigger.

Interview with PSW #132 stated that it was not a good idea to have resident #018 and #019 in the same room since it was known that resident #018 has a responsive behaviour that is triggered from resident #019's responsive behaviour.

PSWs #134 and #139 told the inspector that the home had not implemented the use of a translation, as recommended by the identified outreach team. This would improve resident #018's communication.

Interview with the home's Behavioural Support Ontario (BSO) lead RPN #133 who had started the position in March 2017, reported that resident #018 had an identified responsive behaviour. Resident #019 has a medical condition, and responsive behaviours which triggers resident #018's responsive behaviour; as a result, he/she did not think the two residents were suitable roommates, and the home should have transferred resident #018 to another room sooner than when they did. According to RPN #133 another resident #020 was known to frequent in an identified area of the home. RPN #133 stated that this was also not a good move for resident #018 as resident #020 frequent an area in this room and triggered resident #018's responsive behaviours. The recommendation from the identified outreach team was not implemented. The RPN told the inspector that he/she would work on implementing the identified outreach team recommendation as soon as possible.

RPN #133 and PSW #119 reported that when resident #018 had an identified interaction with resident #019 and #020 on identified dates constituted abuse.

Interview with ADOC #131 and #118 revealed that the home's expectation was a referral for the identified outreach team consultation for resident #018's responsive behaviour and should have been done by the registered staff sooner than the identified date as the resident was already exhibiting responsive behaviours for months.

ADOC #118 stated that resident #018's responsive behaviours were triggered by residents' #019 and #020 responsive behaviours. However, there was no other rooms available on other floors at the time when the resident was transferred into identified room on an identified date, where resident #020 frequent into. ADOC #118 stated he/she

was unsure why one to one monitoring was not started for resident #018's responsive behaviours, and it would have been a decision made by the DOC at that time.

Interview with the DOC who worked in the home since March 2017 acknowledged that resident #019 and #018 were not ideal roommates as resident #019's responsive behaviour was a trigger for resident #018's responsive behaviours which lead to an identified interaction between the two residents. Resident #018 was subsequently transferred into another room where resident #020 did not reside but usually frequented; this lead to two further identified interactions between the two residents. The referral to the identified outreach team for behavioural consultation of resident #018 should should have been done after the first or second incident of the identified responsive behaviour, not after five incidents had occurred. The DOC stated that the home could have done a better job at protecting residents from abuse by resident #018. [s. 19. (1)]

2. Under O. Reg. 79/10, s.2 (1) for the purpose of the definition of "financial abuse" in subsection 2 of the Act, “financial abuse” means any misappropriation or misuse of a resident’s money or property; (“exploitation financiere”)

Record review of CI reported to the MOHLTC that resident #021 alleged that PSW #176 had been accepting money from the resident for taking him/her out of the home and purchasing identified items from the PSW. The resident reported this has been happening for an identified period of time and when the resident refused to give more money to the PSW he/she yelled at the resident.

(i) Resident #021 denied an interview with the inspector.

Interview with PSW #176 revealed that he/she had sold resident #021 identified items once or twice. PSW #176 further revealed that he/she had never yelled at resident #021 at any time.

(ii) Interview with resident #049 revealed that he/she had bought identified made goods from PSW #176 approximately three times for other residents including resident #021. Record review indicated resident #049 has a CPS of one indicative of cognitively alert.

Interview with PSW #176 revealed that when resident #021 did not pay for the identified items resident #049 would pay for it and PSW #176 accepted resident #049's money for the identified items.

(iii) Interview with resident #029 revealed that he/she had purchased prepared items from PSW #176. Resident #029 further revealed that he/she had given the PSW money to purchase items and never received any change or a receipt. Resident felt empty inside, hurt and afraid. Record review indicated that resident #029 has a CPS of two indicative of cognitively intact.

Interview with PSW #176 denies selling items to resident #029 and denies keeping the resident's change from purchases of identified items made on behalf of resident #029.

(iv) Interview with resident #038 revealed that he/she had given PSW #176 an identified amount of money to purchase identified items which cost less than the identified money that was given to him/her and the resident told the PSW to keep the change. Resident #038 further revealed that PSW #176 kept the change from the initial amount. Record review indicated that resident #038 has a CPS of one indicative of cognitively alert.

Interview with PSW #176 told inspector that he/she had purchased identified items for resident #038 approximately four times and had kept resident #038's change.

Interview with PSW #176 revealed that he/she did not recognized his/her actions of selling to resident #021 and #049 made products and keeping resident #038's change from purchase of identified items, as financial abuse and only became aware that it was when the home spoke with him/her.

Interview with DOC #149 revealed that financial abuse occurred between PSW #176 and the residents within the home. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions take with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Record review of CI reported to the MOHLTC indicated that resident #015 was observed on the floor with an injury to an identified body area on an identified date and time.

A review of resident #015's post fall assessments indicated that resident had a history of falls during an identified period, with three of the falls resulting in injury to an identified body area.

A review of resident #015's written plan of care under fall directed staff to monitor the resident at identified intervals when in an identified area of the home and to respond immediately to fall prevention device.

Interviews with PSW #120 and RN #159 revealed that the resident was being monitored at identified intervals when in an identified area of the home. PSW #120 further revealed that he/she was documenting the monitoring in POC.

Interview with Resident Assessment Instrument (RAI) Co-ordinator RPN #193 revealed he/she was unable to locate any documentation in POC of resident #015 being monitored at identified intervals when in an identified area of the home.

Interviews RPN #163, #175 and RN #106 revealed that resident #015 was being visually monitored at identified intervals when in an identified area of the home but there was no documentation available.

Interview with ADOC #118 and DOC revealed that the resident was being monitored but it had not been documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions take with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

Record review of a CI submitted to the MOHLTC indicated an identified interaction between resident #018 and resident #019 in an identified area of the home.

Review of resident #018's clinical record included identified medical conditions.

Record review of the resident's written plan of care indicated behaviour problem related to an identified medical condition as evidenced by responsive behaviours towards co-resident and documented identified interventions.

Record review of resident #018's incident reports revealed five documented incidents of identified interactions between resident #018 and co-residents.

Record review of CIs submitted to the MOHLTC reported resident to resident identified interactions mentioned above that had occurred on identified dates.

According to resident #018's progress notes, he/she was roommates with resident #019 until an identified date when resident #018 was transferred into another room due to the identified interactions with resident #019 on identified dates. Subsequently, two more identified interactions occurred in an identified area of the home between resident #018 and #020 on identified dates; resident #018 was then transferred to a different floor on an identified date.

Record review of resident #018's clinical record revealed a referral to an identified outreach team was completed on an identified date and the resident was later assessed.

Interview with RN #117 revealed that he/she completed a referral for assessment of resident #018's responsive behaviours by the identified outreach team on an identified date and it should have been done sooner as the resident had been exhibiting responsive behaviours and documented incidents of identified interactions. Resident #018 has responsive behaviours related to an identified trigger.

Interview with PSW #132 stated that it was not a good idea to have resident #018 and #019 in the same room since it was known that resident #018 has a responsive behaviour that is triggered from resident #019's responsive behaviour.

PSWs #134 and #139 told the inspector that the home had not implemented the use of a translation sheet, as recommended by the identified outreach team. This would improve resident #018's communication barrier.

Interview with the home's Behavioural Support Ontario (BSO) lead RPN #133 who had started the position in March 2017, reported that resident #018 had an identified responsive behaviour. Resident #019 has a medical condition, and responsive behaviours which triggered resident #018's responsive behaviour; as a result, he/she did not think the two residents were suitable roommates, and the home should have transferred resident #018 to another room sooner than when they did. According to RPN #133 resident #020 was known to frequent in an identified area of this room; this was the

room that resident #018 was transferred into. RPN #133 stated that this was also not a good move for resident #018 as resident #020 frequent an area in this room which triggered resident #018's responsive behaviours. The recommendation from the identified outreach team was not implemented. The RPN told the inspector that he/she would work on implementing the identified outreach team recommendation as soon as possible.

Interview with ADOC #131 and #118 revealed that the home's expectation was for a referral for the identified outreach team consultation for resident #018 's responsive behaviour should have been done by the registered staff sooner than the identified date as the resident was already been exhibiting responsive behaviours for months. ADOC #118 stated that resident #018's responsive behaviours were triggered by residents' #019 and #020 responsive behaviours. There was no other rooms available on other floors at the time when the resident was transferred into identified room on an identified date, where resident #020 frequent into. ADOC #118 stated he/she was unsure why one to one monitoring was not started for resident #018's responsive behaviours, and it would have been a decision made by the DOC at that time.

Interview with the DOC who worked in the home since March 2017 acknowledged that resident #019 and #018 were not ideal roommates as resident #019's responsive behaviour was a trigger for resident #018's responsive behaviours which lead to an identified interaction between the two residents. Resident #018 was subsequently transferred into another room where resident #020 did not reside but usually frequented; this lead to two more identified interactions between the two residents. The referral to the identified outreach team for behavioural consultation of resident #018 should should have been done after the first or second incident not after five incidents had occurred. The DOC confirmed that resident #018's written plan of care was not updated with any new behavioural interventions until after the resident had three incidents of an identified interaction with resident #019 and two incidents with resident #020. [s. 54. (b)]

2. Record review of CI reported to the MOHLTC indicated that resident #022 was exhibiting an identified responsive behaviour in an identified area of the home upsetting many residents. Staff #144 observed an identified incident between resident #021 and #022.

A review of the home's Incident Report for an identified period indicated that resident #021 was involved in five incidents that had occurred with co-residents in an identified area of the home.

A review of resident #021's written plan of care did not indicate any interventions to direct staff how to manage resident #021's responsive behaviours while he/she is in an identified area of the home.

Interview with staff #152 and #154 revealed that he/she is not sure if resident #021 is being supervised while in an identified area of the home.

Interviews with PSW #142 and RPN #146 revealed that resident #021 spends most of his/her time in an identified area of the home. RPN #146 and ADOC #131 revealed that most incidents with resident #021 occurred in the identified area of the home.

Interview with ADOC #131 and DOC revealed that there were no interventions developed in resident #021's plan of care to minimize the risk of altercations and potentially harmful interactions between and among residents when they are in an identified area of the home. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based upon to the Director.

Record review of CI submitted to the MOHLTC reported resident to resident abuse. Resident #018 was sitting on his/her bed and saw co-resident #019 in an area of the home. Resident #018 ran towards resident #019 and an identified incident resulted. Both residents were separated by staff. Resident #019 was assessed by the registered staff and head injury routine (HIR) started.

Interview with ADOC #118 revealed that he/she submitted the above mentioned CI on an identified date reporting resident to resident abuse between resident #018 and #019 on an identified date. It was not reported to the Director immediately as there was no DOC at the time of the incident, and he/she had no access to submitting the CI until a later identified date. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Record review of CI reported to the MOHLTC indicated an identified date resident #040 slipped on the floor and fell and was diagnosed with an injury to an identified body part.

During an observation on an identified date resident #009 was observed by inspector in bed and PSW #147 was observed taking a roommate #052 into the tub room to be changed. An interview with PSW #147 revealed that the toilet in the residents' room was out of order.

A review of resident #009's written plan of care indicated that resident #009 required extensive assistance from staff and the resident stays in an area of the home for long periods of time. The care plan also indicated under falls that the resident is at risk for falls due to unsteady gait.

Interview with PSW #179 revealed that resident #009 uses an identified item and disposes inappropriately in an identified area of the home and he/she has to check on the resident at intervals to ensure the resident's safety.

Interview with RPN #187 revealed that resident #009 has responsive behaviour of using an identified item and disposing inappropriately in an identified area of the home. RPN told inspector that staff had to monitor when resident #009 goes to an identified area of the home to check on resident's safety. RPN revealed that these behaviours have been ongoing for several months and was not in the resident's written plan of care.

Interview with RPN #196 revealed that resident #009 spends long periods of time in an identified area of the home and does not leave therefore roommate has to go to a different identified area of the home. The resident removes an identified product type and when he/she is not given one will take the identified product type from roommates. RPN told inspector that these behaviours and strategies were not in the resident's written plan of care.

Interview with ADOC #131 revealed that these responsive behaviours should be in the identified resident's written plan of care.

Interview with DOC revealed that he/she was unaware of the identified behaviours and will start the resident on monitoring. [s. 26. (3) 5.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record relating to the home's responsive behaviour evaluation that included date of the evaluation, names of the persons who participated, summary of the changes made, and date that those changes were implemented.

Record review of the home's annual responsive behaviour evaluation for 2016, and interview with the ADOC #131 confirmed that the date had not been included on the annual evaluation. [s. 53. (3) (c)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents.

A review of five employee personnel files was conducted as a result of non-compliance related to alleged staff to resident financial abuse.

Record review of five employees personnel files revealed that employee #151 had been hired on an identified date and had not completed the home’s mandatory training on the home's abuse and neglect policy.

Interview with employee #151 revealed that he/she had signed a checklist indicating that he/she had competed the mandatory training on the home's abuse and neglect policy however, he/she did not do the actual training but was scheduled to complete it on an identified date. This checklist was co-signed by the DOC, who revealed the employee did not complete the abuse and neglect training of the home's policy at the time of signing the checklist.

Interview with ED revealed that the mandatory training had not been completed by employee #151 at the time of hire and he/she was working on having the training completed. [s. 76. (2) 3.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, was promptly prepared.

Record review of the home's annual evaluation of the policy to promote zero tolerance of abuse and neglect for 2016, did not include the date of the evaluation and the date that the changes and improvements were implemented.

Interview with the ADOC #131 confirmed that the above mentioned evaluation was completed, but the evaluation did not include the date nor the date that the changes and improvements were implemented. He/she also informed the inspector that some of the people listed as participants in the evaluation, actually did not participate. [s. 99. (e)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital that results in a significant change in the resident's health condition.

Record review of CI reported to the MOHLTC indicated on an identified date resident #040 slipped on the floor and fell and was diagnosed with an injury to an identified body part.

Interview with RN #180, RPN #178, PSWs #177 and #179 revealed that resident #040 fell on an identified date.

Interview with DOC revealed that he/she submitted the CI late after the fall. [s. 107. (3)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 151. Obstruction, etc.
Every person is guilty of an offence who,
(a) hinders, obstructs or interferes with an inspector conducting an inspection, or otherwise impedes an inspector in carrying out his or her duties;
(b) destroys or alters a record or other thing that has been demanded under clause 147 (1) (c); or
(c) fails to do anything required under subsection 147 (3). 2007, c. 8, s. 151.

Findings/Faits saillants :

1. The licensee has failed to ensure that every person is guilty of an offence who destroys or alters a record or other thing that has been demanded under clause 147 (1) (c).

(i) Record review of the home's annual evaluation of the home's policy to promote zero tolerance of abuse and neglect for 2016, did not include the date of the evaluation and the date that the changes and improvements were implemented.

Interview with the ADOC #131 confirmed that the above mentioned evaluation was completed, but the evaluation did not include the date nor the date that the changes and improvements were implemented. He/she also informed the inspector that some of the people listed as participants in the evaluation, actually did not participate.

(ii) Record review of five newly hired employee personnel files revealed that employee #151 had been hired on an identified date and had not completed the home’s mandatory training on abuse and neglect.

Interview with employee #151 revealed that he/she had signed a checklist indicating that he/she had completed the mandatory training on abuse and neglect however, he/she did not do the actual training and was completing it on an identified date. This checklist was co-signed by the DOC, who revealed the employee did not complete the abuse and neglect training at the time of signing the checklist.

Interview with ED revealed that the mandatory training had not been completed by employee #151 at the time of hire and he/she was working on having the training completed. [s. 151. (b)]

Issued on this 29th day of July, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.